

several cases. Some of these are recorded by him in the *Annales de la Soc. de Med. d'Anvers*, for May last.

22. *Unusual form of Intussusception of the Colon.*—Dr. HARRISON communicated to the Surgical Society of Ireland, (Feb. 15, 1845,) the following case. The patient, when first seen by Dr. H., was much emaciated, and with a countenance expressive of great suffering and distress, such as is observed in internal malignant disease. Vomiting was so incessant that the patient could hardly speak. On examination, a tumour about the size of an orange was found near the umbilicus, between it and the ribs of the left side; it could be moved up and down, and was free from pain at times, except on pressure. Dr. H. was much in doubt about the nature of this tumour, but formed a conjecture that it was a malignant growth from the omentum between the colon and stomach. He saw that it could not be an aneurism, and its situation was too low to induce him to suppose the disease was connected with either the liver, spleen, or stomach. He would not enter into a detail of the various remedies employed, all of which completely failed to give the slightest relief. The poor man was at times very free from suffering, but at others he would scream out and say—"Kill me, or cut me open!" The only medicine that at all benefited him was opium, which he continued to take till his death. On examination of the abdomen after death, very little appearance of disease presented itself at first. There was no general inflammation of the peritoneum or of the omentum; but on raising up the latter structure, and examining the colon, an intussusception of this intestine was seen to have taken place, the descending portion of it being carried up to the transverse arch, probably for an extent of three or four inches. The transverse arch being laid open, Dr. Harrison exhibited the lower portion of intestine lying in the upper, with its orifice resembling an os uteri, projecting into a dilated vagina; this contracted appearance of the orifice might, he thought, in some degree, account for the violence of the pain that had been suffered. The intussuscepted portion of the intestine was found in an ulcerated condition, accounting for the unhealthy discharge that had existed during life. Here was a very remarkable form of intussusception totally unlike those usually seen. When Hunter, in speaking of the affection, observes that such an occurrence is possible, he talks of the two species of the disease—the one progressive, in which the invagination may go on increasing from above downwards—the other, the retrograde form, the lower portion of the tube being received into the upper, as in the case under consideration; however, he gives no example of this occurrence. Sir Everard Home mentions one case of the retrograde species in the small intestines—a point in which the present case possessed additional interest, for the intussusception was here situated in the colon, while the small intestines or the cæcum are the parts usually involved. Cruveilhier had never met with this form of the disease, and gives no plate representing the affection. Various opinions respecting the nature of the case were entertained, not one who saw it having diagnosed it, except indeed Dr. Law, who, when he first examined the patient, at once observed that he knew of nothing it resembled so strongly as intussusception. For himself, he must confess he had not for a moment formed such an opinion. No remedy is known for the disease; the boasted one of the ancients—metallic mercury—being found to be as inefficacious as the rest; purgatives given by the mouth can effect nothing; Hunter says they generally do more harm than good; he conceives that violent vomiting might reverse the peristaltic action, but he (Dr. Harrison) believed very little reliance could be placed on any aid of a mechanical nature. With the exhibition of opium and perfect quiet, it might be hoped that an adhesion would take place between the opposed serous surfaces of the intestine and the internal cylinder, by this means gradually discharged by the anus; for many cases have been observed in which so many as two or three feet of intestine had come away. The present case, in which no hope of a favourable issue could be at all calculated on, might (had a diagnosis of its true nature been made) have been a good one for the lumbar operation. Had an opening been made in the right lumbar colon, a little above the cæcum, it might reasonably be expected that he would have survived. With regard to the operation of opening the colon in the lumbar region, it appeared to him, judging anatomically, that the right ought to be chosen in prefer-

ence to the left portion of it, which latter was the one hitherto selected. The right division would be found to be least covered by peritoneum, and to have much less mesocolon, and on making examinations of both portions he had found the right colon generally deficient of peritoneum on its posterior aspect. He thought this case would be interesting to the society for many reasons—the length of time the patient had endured it, upwards of two months, it being an instance of the retrograde species, the impossibility of diagnosing it, and its relation to the very interesting subject lately under discussion—*Dub. Med. Press*, March 5, 1845.

23. *Observations on the Mechanism and Diagnostic value of the Friction Vibrations perceived by the Ear and by the Touch in Peritonitis.*—The *London and Edinburgh Monthly Journal* for May last, contains an interesting paper on this subject by Dr. ROBT. SPITTAL. The author conceives that the following conclusions may be drawn from the observations thus far made:

That the mechanism by which the friction vibrations are produced is of three kinds, viz.

1. The respiratory movements,—of the diaphragm chiefly,—but also the action of the abdominal muscles. The vibrations being synchronous with these movements, though sometimes only developed during inspiration.

2. Artificial movement of the parts by pressure with the hand or otherwise. The vibrations corresponding in their rhythm to the movement produced.

3. The peristaltic motion of the intestinal canal,—imparting to the vibrations a peculiar, continued rustling, and creeping character to the ear and hand, corresponding to the vermicular motion of the intestines.

That the immediate cause of the friction vibrations is the rubbing together of two peritoneal surfaces, physically altered by the inflammatory process; and although the effusion of lymph has been considered necessary for their production, it appears highly probable that at a prior stage of the inflammation, when the peritoneum is merely drier than usual, friction vibrations may take place.

That the more the surfaces are moistened, the less intense will be the friction vibrations; and when a liquid effusion is sufficient to separate the surfaces, the vibrations will cease altogether at the part; but by altering the position of the patient, so as to enable the liquid to gravitate to some other part, and thus bring the surfaces together again, the friction vibrations will be renewed.

That the amount of motion between the inflamed surfaces, necessary for the production of the friction vibration, is very limited; and that different modes of friction, as to rapidity and degrees of pressure, may not only modify the intensity, but also the tone and quality of the vibrations.

That the present state of our knowledge does not permit us to connect any particular species of vibration with a certain physical condition of the peritoneum, although reasonable grounds exist for this expectation.

That although the friction vibrations are no evidence of the existence of adhesions between the peritoneal surfaces, it has not been proved, that in the case of partial adhesions,—and even when the adhesions are general, provided the effused lymph be recent, soft, and extensible,—an amount of motion sufficient to produce the friction vibrations might not occur.

That the respiratory abdominal friction vibrations are chiefly manifested at the upper part of the abdominal cavity, where its more solid contents are situated, and in the case of a large organic tumour,—and may be regarded as indicative of the inflammation existing over a solid organ or tumour.

That the indications from artificial movement of the parts have been perceived, both where tumours were present, and where the intestines alone, or along with the omentum, were the site of the inflammation.

That the peristaltic friction vibrations indicate that the peritoneum investing the corresponding portion of the intestinal tube is the part affected.

That wherever the peristaltic vibrations are *very distinctly perceived*, they may be regarded as indicative of a lively and free motion of the folds of intestine upon one another, and upon the parietes; and of few or no adhesions existing between them. At all events, it shows that the intestines are not generally adherent, nor matted together into an adherent mass, nor, to any great extent, adherent to the abdominal parietes.